MANUAL

FOR

FIRST TRIMESTER

MEDICAL TERMINATION OF PREGNANCY

Issued by
Technical Operations Division
Ministry of Health & Family Welfare
(Department of Family Welfare)
Government of India
Nirman Bhavan, New Delhi-11.

05371

Community Health Cell
Library and Documentation Unit
367, "Srinivasa Nilaya"
Jakkasandra 1st Main,
1st Block, Koramangala,
BANGALORE-560 034.
Phone : 5531518

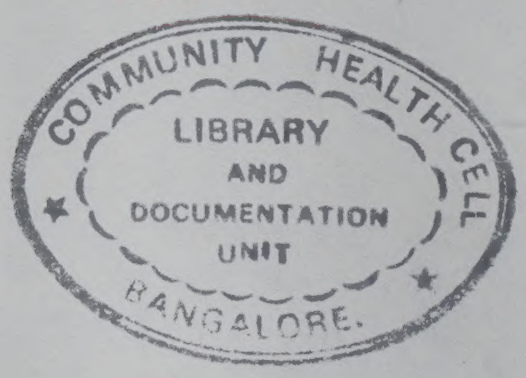
MANUAL

FOR

FIRST TRIMESTER

MEDICAL TERMINATION OF PREGNANCY

TM-120
05371 N94



PREFACE

The continued demand for abortion services is a reflection of the unmet need for avoiding unwanted pregnancies. Since the Medical Termination of Pregnancy (MTP) Act was enacted by the Parliament in 1972, MTP has become a major instrument for protection of maternal health. It has also become a major entry point for introduction of contraceptives concomitantly, which in turn would reduce unwanted pregnancy. Therefore, it is important to ensure that Medical Termination of Pregnancy is carried out by skilled hands under hygienic conditions with minimal hazard to maternal health.

This manual for conducting Medical Termination of Pregnancy during First Trimester will help the Medical Officers in selection of patients, proper counselling, using correct technique for MTP, post operative care and follow up etc. This Manual will also familiarise them with various important aspects of the Medical Termination of Pregnancy Act.

My thanks are due to the experts who have contributed to the preparation of this Manual and the staff members of the Ministry who have helped in bringing out the publication.

(ADARSH MISRA)
JOINT SECRETRY TO THE
Government of India

Date_____
New Delhi-110011.

CONTENTS

1.	**Introduction**		1
2.	**Equipment**		2
	2.1	Suction machine and tubing	
	2.2	Menstrual regulation syringe	
	2.3	Suction cannulae	
	2.4	Ancillary instruments	
	2.5	Essential drugs	
3.	**Patient counselling**		5
	3.1	Supportive counselling	
	3.2	Contraceptive counselling	
4.	**Patient selection**		7
	4.1	Clinical Assessment	
	4.2	Investigations	
5.	**Pre-operative Card & Pain control**		9
	5.1	General instructions	
	5.2	Origin of pain	
	5.3	Choice of pain control methods	
	5.4	Sensitivity testing for local anaesthesia	
	5.5	Technique of local anaesthesia	
6.	**Surgical procedures**		11
	6.1	Techniques of suction evacuation	
	6.2	Technique of menstrual regulation	
	6.3	Technical problems	
	6.4	Dilatation & Evacuation	
7.	**Post-operative care**		17
	7.1	Monitoring	
	7.2	Instructions on discharge	
	7.3	Follow up	
8.	**Non-Surgical Methods**		19
	8.1	Hygroscopic Agents (slow dilatation of cervix)	
	8.2	Medical Methods of MTP	
9.	**Complications & management**		21
	9.1	Immediate	
	9.2	Delayed	
	9.3	Remote	
10.	**Infection Control**		27
	10.1	Universal Precautions	
	10.2	Sterilization & Maintenance of Equipment	
11.	**Conclusion**		33

Annexure 1 : MTP Act 34

OBJECTIVE

The objective of this module is to impart the necessary knowledge and technical skill for performing first fotrimester termination of pregnancy so that the medical officers can provide well organised, safe and effective MTP services at their centers.

1. INTRODUCTION

1.1 LIBERALISATION OF ABORTION LAWS

During the past two decades, there have been worldwide liberalisation of abortion laws. To reduce the collosal maternal morbidity & mortality associated with illegal abortions. Shantilal Shah Committee (1964) recommended liberalisation of abortion laws in India in 1966. In 1969, MTP Bill was introduced in Rajyasabha and Loksabha. The Bill was passed by the Parliament in August 1971. It came into force from 1.4.1972. Even after 20 years of implementation of the Act, incidence of illegal abortions continues to be high and deaths due to septic abortion in rural areas have not shown a substantial decline.

1.2 WHY UNSAFE ABORTIONS STILL PREVALENT?

Public ignorance of the law and lack of information about the available government facilities is partly responsible for the large number of unsafe abortions which are readily accepted by women, because of easy availability at low cost. In rural areas, govt. hospital abortion services are not readily available. Whereas in urban settings there are long waiting hours, lack of privacy and impersonal services at government centres, and high cost at the private approved centres. Besides this unmarried girls may be reluctant to go to the hospitals and clinics.

A large number of terminations are also being performed by registered medical graduates who are not properly trained or the methods used are unsafe or the place where the MTP is performed is not approved by the competent authority.

1.3 NEED FOR WELL ORGANISED SERVICES

While legal abortion today is a safe surgical procedure it still cannot be taken lightly. There can be serious complications, if high risks cases are not recognised and MTP is performed without adequate back up services. This may result in immediate complications which may prove fatal, as well as lead to long term morbidity.

2. EQUIPMENT, DRUGS & ANCILLIARY INSTRUMENTS

The equipment & supplies required for performing first trimester abortion include:

a) Suction machine with connecting tubing
   * Electric or,
   * Manual (Hand or foot operated) or,
   * Electric-cum-Manual.

b) Menstrual Regulation syringe,

c) Suction cannulae,

d) D&C set

e) Other instruments,

f) Essential drugs.

2.1 SUCTION MACHINE (fig. 1)

Suction machine used for termination of pregnancy should rapidly develop a negative pressure of 60-70 cm of mercury within 70 seconds and also should have a minimum free air displacement of 25-30 ml/min for effective suction of the products as per BIS specifications. Pressure less than 60 cm of Ho does not provide effective suction thereby increasing the likelihood of incomplete abortion: higher pressure may produce safety traps.

A wide variety of Indian make suction machines are now available ranging from simple hand or foot operated vacuum pumps to sophisticated high capacity pumps with explosion proof safety traps.

CONNECTION TUBING

The tubing connecting the cannula to the suction machine should be a light weight, flexible plastic tubing which does not collapse with high vacuum.

Corrugated plastic tubing is difficult to decontaminate and hence should not be used.

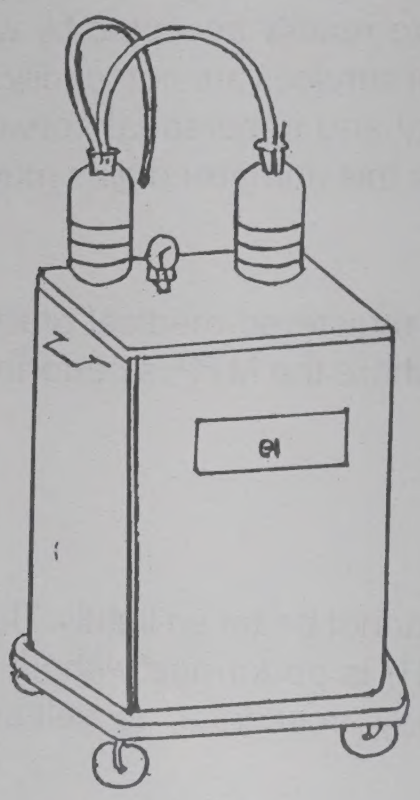
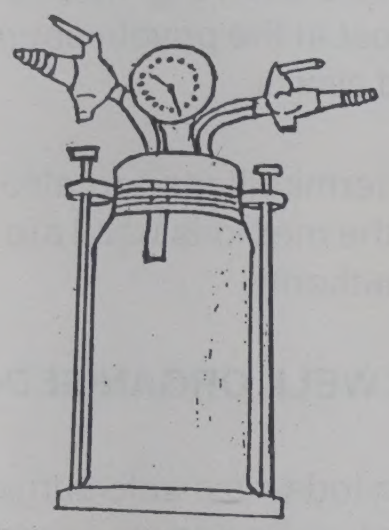


FIG.1 Suction Machine



Suction Machine with manometer to gauge the pressure

2.2 MENSTRUAL REGULATION SYRINGE. (Fig. 2)

It is a 50 ml polyethylene syringe capable of producing a vacuum of 65cm. of Hg. at sea level. The vacuum is created and retained by the piston of the syringe which has special catcher arms to hold the plunger at full extension and lock the piston. The collar stop prevents inadvertent withdrawal of plunger from the syringe. There is a simple pressure control valve near the tip, which permits preloading of the syringe as an independent step and allows the vacuum to be transferred to the cannula, which is attached later to the tip of the syringe.

2.3 SUCTION CANNULAE (Fig. 3)

The cannulae used for suction aspiration are available in different sizes: 4mm & 6mm for menstrual regulation and No. 6 to 12 for suction evacuation for corresponding periods of gestation.

Different varieties are available :

1) Plastic : Rigid Flexible

2) Metal

Plastic cannula is commonly used. It is transparent, allowing the operator to see the contents of the uterus being aspirated.

Flexible plastic cannula has a sealed rounded end with two lateral triangular or boat shaped subterminal openings, located on positive sides with an overhanging convex hood which act as a curette. Rigid plastic cannula is slightly angled and usually has one subterminal opening. Flexible cannula bends easily and therefore has less chance of perforating the uterus but as it sticks to the uterine wall, the opening may get blocked with products and sometimes the tip gets shipped off.

Metal cannulae have a thumb plate with an air hole near the proximal end for rapid release of vacuum. Although the metallic cannulae have a disadvantage of inability to see the contents being aspirated, they are reusable, cost-effective and easy to sterilize. Metal cannulae also provide a larger inner diameter for similar outer diameter.

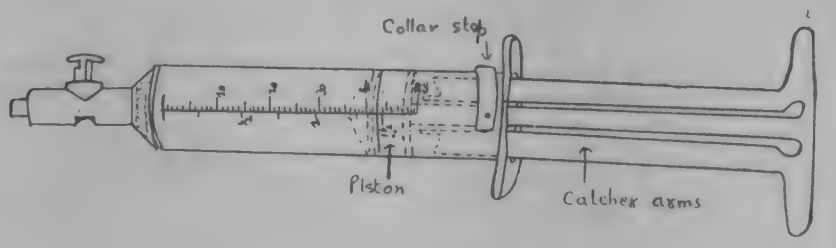


Fig. 2. Menstrual Regulation Syringe

Fig. 3 Suction Cannulae (Flexible plastic)

Metal Cannula

Sims' Speculum

Anterior Vaginal wall Retractor

Uterine sound

Sharp and Blunt curette

Sponge Holding Forceps

Volsellum.

Cervical Dilators

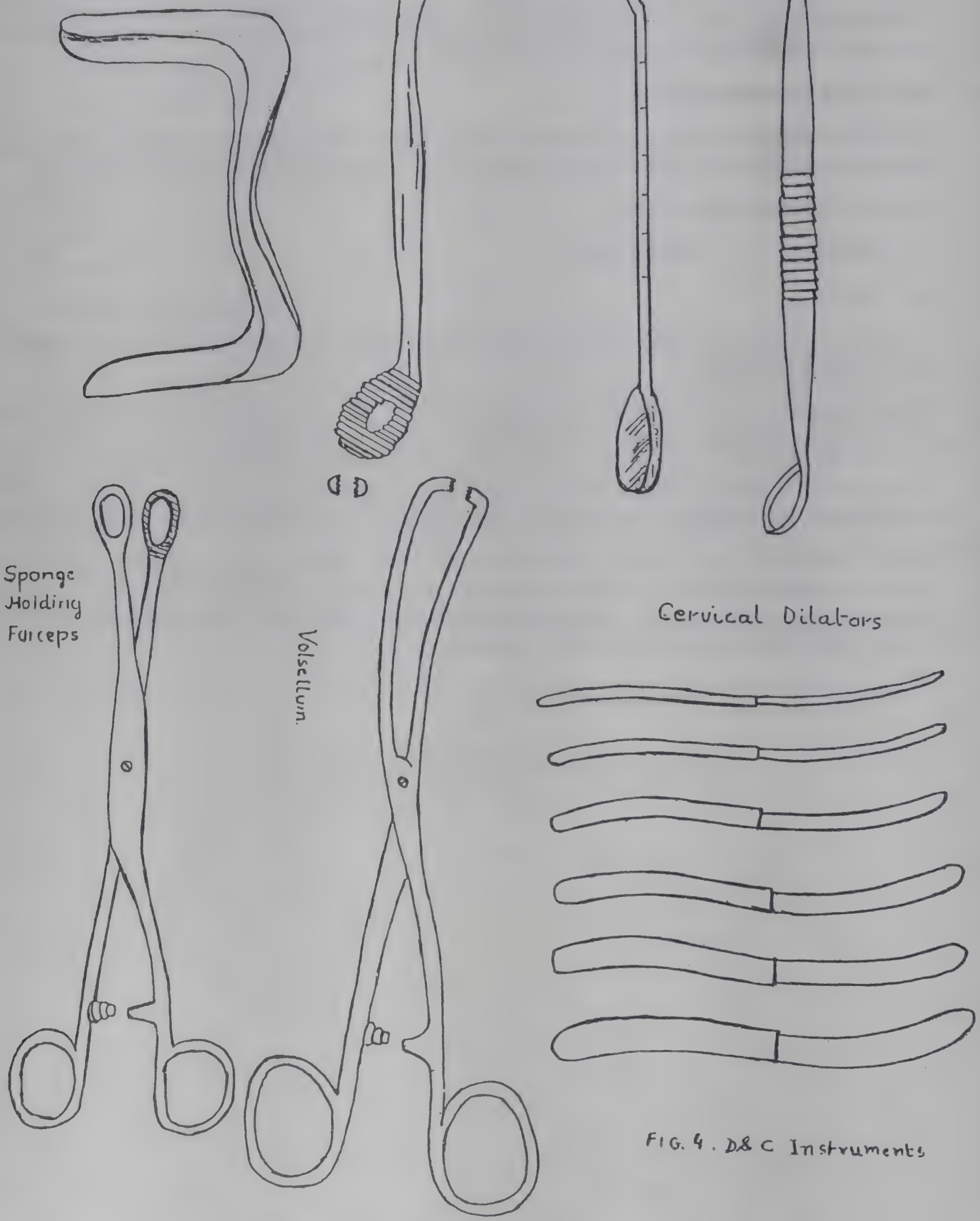


FIG. 4. D&C Instruments

3. PATIENT COUNSELLING

Counselling should be an integral part of the abortion procedure as the woman undergoing a termination of pregnancy may be under several sociological and psychological stresses. The process of decision making may be difficult for her and she may need help.

3.1 SUPPORTIVE COUNSELLING

* Counsellor should establish a rapport with the patient to allay her anxiety and provide her with accurate and unbiased information in a simple language.
* The woman should be properly briefed about the method of abortion, choice of anaesthesia, type of sensations she can expect during the procedure and the associated risks.
* The woman should consent to the procedure after fully understanding the choices available and the risks associated with the procedure.
* Finally some information of the basic reproductive anatomy, physiology and contraceptive choices available may be given so that she understands how to prevent future unplanned pregnancy.

3.2 CONTRACEPTIVE COUNSELLING

A firm plan for future fertility regulation should be discussed during the initial interview so that it can be implemented at the time of operation or immediately afterwards, as the time of an abortion often becomes the turning point in a woman's acceptance of contraception.

Roughly 75% women ovulate and 6% conceive within 4-6 weeks after abortion, unless they are using contraception. Further many of them do not return for follow up and miss the opportunity to obtain contraception. There is no need to wait for 2-6 weeks before inserting an IUD, advising pills or sterilisation.

Any Contraceptive method can be safety provided immediately after the MTP

* **Intrauterine device**

  The continuation rate for post abortion IUD insertion are good; Concurrent IUD in case of complete abortion is not associated with higher risk of complications.

* **Sterilisation**

  Abdominal tubectomy can be safely performed concurrently with MTP.

Thus it is important that all out efforts should be made to convince the woman for adoption of post-abortal contraception, stressing the risks associated with the occurrence of unwanted pregnancies and repeated terminations. However, MTP should not be denied even in case of non-acceptance of contraception, in order to prevent the woman from seeking unsafe illegal abortions.

MTP should not be refused even if concurrent contraception is not accepted.

4. SELECTION OF PATIENTS

Although first trimester pregnancy termination is a relatively simple procedure, nevertheless, it may be associated with a number of minor or major complications resulting in significant maternal morbidity and mortality. Therefore before commencing the procedure, it is imperative to make a proper patient selection.

4.1 CLINICAL ASSESSMENT

One must obtain a good history and perform complete general, systemic and gynaecologic examination for :

a) Confirmation of pregnancy,

b) Assessment of exact period of gestation,

c) Associated gynaecological disorders & infection,

d) Associated medical problems.

The findings should be recorded in a proforma.

ASSESSMENT PROFORMA

* Demographic Information
  Age, Marital status, Occupation, Religion,
  Education, No. of living children, Age of youngest child,
  Sex of children.

* History
- Menstrual-cycle length, Date of LMP
- Obstetric-parity, live births, abortions, prev. LSCS
- Contraceptives used
- Reasons for MTP
- Medical illness
- Pelvic or abdominal surgery
- Drug allergy
- Immunization status

* General and systemic examination
- Pulse, B.P.
- Pallor, Jaundice
- Heart, Lungs

* Pelvic examination
- Size and direction of uterus
- Pelvic masses, tenderness

Confirmation of pregnancy is essential as the patient may not be pregnant at all and amennorhoea may be due to lactation or other abnormalities as vesicular mole or extrauterine pregnancy. It is not uncommon to see cases, where these conditions have been missed, leading to problems and complications at a later date. In case of any doubt refer the case to a higher centre.

Establishing the period of gestation may be difficult if

* Date of last menstrual period not remembered.
* Conception during lactational amennorhoea.
* Wrong dates provided intentionally as by unmarried.
* Previous irregular cycles or pill usage.
* Obesity.
* Presence of fibroids.

In order to avoid getting into complications after starting the procedure, one must assess the uterine size properly during bimanual palpation. It is recommended that the PHC level, termination should not be attempted if the uterine size is large than 8 weeks, even if duration of ammenorhoea is less than 8 weeks.

Associated gynaecological infections

Vaginitis and cervicitis with purulent discharge should be detected and treated before operation.

Associated medical problems such as

* Anaemia
* Hypertension
* Heart disease
* Renal disease
* Diabetes mellitus
* Bleeding diathesis

These cases should referred to a higher centre as termination in these cases requires specialist care and extra facilities which may not be available at the PHC.

Similarly MTP in a woman with **previous uterine surgery** should only be carried out at a place where facility for laparotomy is available because of the risk of perforation uterus.

MTP NOT TO BE CONDUCTED AT PHC LEVEL

* Nulliparous woman
* Previous ceasarean section
* Period of gestation more than eight weeks
* Pregnancy with fibroid uterus
* Haemoglobin below 8 gm%.
* Any associated medical diorders.

MTP is avoided at PHC because of higher risk of complications and non-availability of backup services.

4.2 INVESTIGATIONS REQUIRED INCLUDE :

Haemoglobin level

Urine for albumin and sugar

5. PRE-OPERATIVE CARE & PAIN CONTROL

5.1 GENERAL INSTRUCTIONS

* The client should be accompanied by a responsible person.
* The client should not eat anything 6 hours before surgery.
* She must bathe and wear clean & loose clothing to the OT.
* She must not wear any jewellery or nail polish to the OT.
* Shaving the perineum and vulva is not required.
* Inj. Tetanus toxoid should be given before the procedure.

PAIN CONTROL

The purpose of pain control is to ensure that the woman suffers minimal anxiety, discomfort and risk to her health.

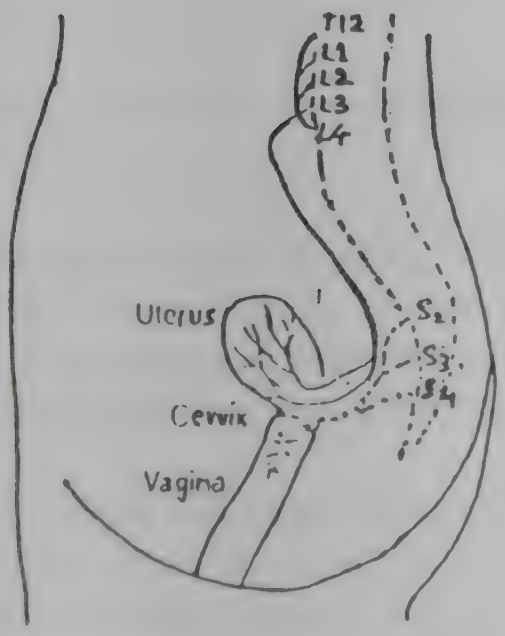
5.2 ORIGIN OF PAIN

Woman may experience two types of pain:

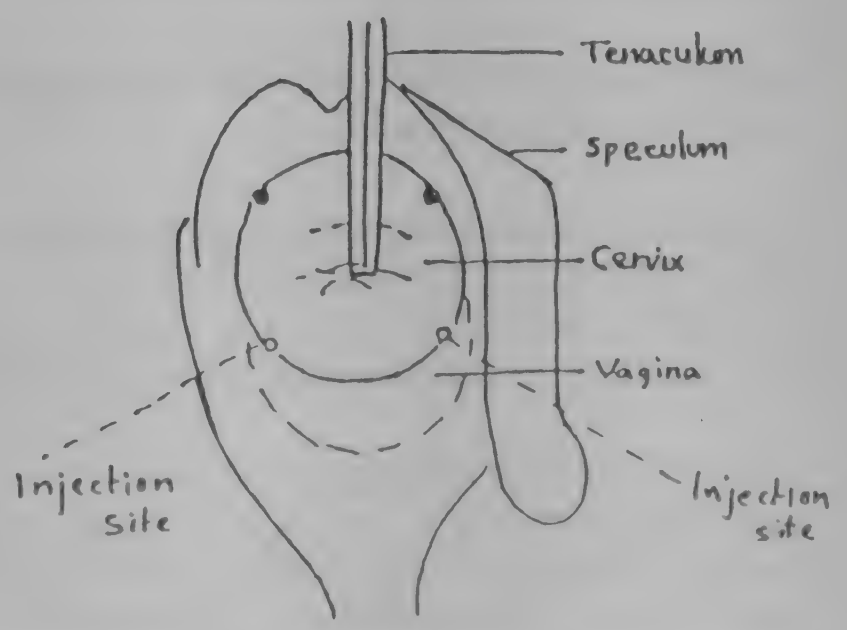
a) The deep intense pain accompanying cervical dilatation, transmitted by dense network of nerves surrounding the cervix.

b) Diffuse lower abdominal pain with cramping occuring with the movement of the uterus, scraping of uterine wall and the muscle spasm related to emptying of the uterine cavity. Uterine pain is transmitted from the funds along major uterine nerves that follow uterosacral and utero-ovarian ligaments.

Besides this any rough handling can cause pain and any anxiety the woman feels will increase her sensation of pain. So gentle handling and sensitive treatment are essential.



Transmittal of Pain Sensations from Uterus and cervix.



Local anaesthesia. Pericervical block

5.2 CHOICE OF PAIN CONTROL MEDICATION

Pain control medication fall into three categories :

Analgesics alleviate the sensation of pain in receptors of the spinal cord and brain. Narcotics, one type of analgesic induce stupor as well as block the transmission of pain.

Anxioloytics depress the functions of the CNC and do not actually reduce pain. They reduce anxiety, produce calm and relax muscles.

Anaesthetics numb all physical sensations either locally, regionally or generally.

Usually patient need not be unconscious for pain control unless she is extremely young, very anxious or has significant cervical stenosis. In these cases termination should be done at centres with facilities for GA.

Generally a gentle supportive treatment of the patient with combination of analgesic, a mild anxiolytic and local anaesthesia (paracervical block) provides excellent pain control for first trimester abortions.

Communication must be maintained with the patient throughout the operation and she should be responsive so as to alert the surgeon in case of any complications.

5.3 SENSITIVITY TESTING

SENSITIVITY TESTING should be done for local anaesthesia with 0.2 ml. of the drug injected intradermally with 25 gauge needle. Observe the patient for a minimum of ten minutes. A raised wheal, erythema or general reaction indicates sensitivity to the drug.

5.4 TECHNIQUE OF LOCAL ANAESTHESIA

Paracervical or Pericervical block is carried out the block is carried out to block the sensory output from the cervix and the uterus.

In classical paracervical block, injection of the local anaesthetic agent is made through the reflected vaginal epithelium, to a depth of 2-3mm. at the cervico-vaginal junction at 3 and 9 O'clock positions around the cervix. The procedure requires use of a special needle with a guard and is associated with a risk of intravasation into the vessels, broad ligament haematoma and parametritis.

In the Pericervical technique, the injection is made in the pericervical tissues at three or four places, to a depth of 3-4 cm. Ordinary 22 gauge hypodermic needle is used 10 ml. of 1.0% lignocaine without adrenaline is injected in divided doses at 2,4,8 and 10 'O' clock positions. Before each injection, the plunger should be withdrawn to avoid the possibility of intravascular injection. The technique is simple and takes two to three minutes for the effect.

6. SURGICAL PROCEDURES

Surgical procedures for first trimester pregnancy termination include:

* Suction evacuation
* Menstrual regulation
* Dilatation & evacuation

6.1 SUCTION EVACUATION

Rapid dilatation of cervix is done with graduated dilators followed by evacuation of uterine contents with a suction cannula and curettage using ablunt curette. The method is simple, rapid, less traumatic and has become the standard procedure for first trimester abortion throughout the world.

TECHNIQUE

1. **Make the patient pass urine and put her in lithotomy position on the table,** with the legs in the stirrups (Fig. 5). Clean the lower part of abdomen, perineum and vagina thoroughly with suitable antiseptic lotion eg. 3% cetrimide/Ethanol/providone iodine) and drape with sterile perineal sheet.

2. **Determine the size and position of the uterus** by careful bimanual pelvic examination (Fig. 6).

3. **Expose the cervix** by retracting the posterior vaginal wall with Sim's speculum and anterior vaginal wall with A.V. retractor respectively and stabilise the anterior lip of cervix with a volsellum or long Allis foreceps (Fig. 7).

4. **Give local anaesthesia** as described in section 5.

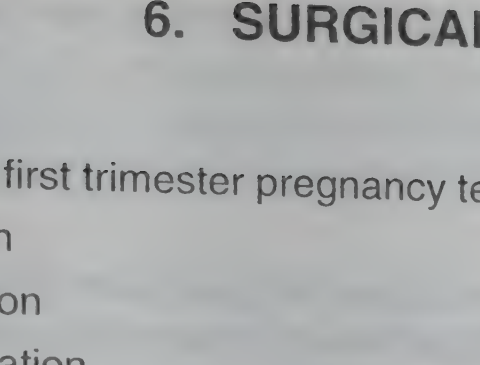


FIG. 5. Lithotomy position

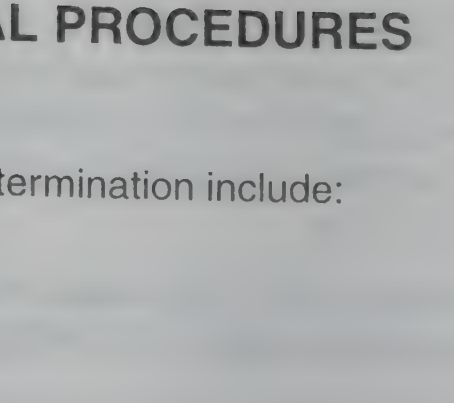


FIG. 6. Bimanual examination of pelvis

FIG. 7 Stabilising anterior lip of cervix with Volsellum

5. **Dilate the internal os of the cervix** with graduated, tapering metal dialators. Also apply simultaneous traction on the volsellum to straighten the anteverted or retroverted uterus. Hold the dilator with a 'pen grip'. The little finger should act as a guard by abutting against the perineum to prevent, sudden uncontrolled entry of the dilator into the uterine cavity which may cause perforation. (Fig. 8, 9).

The extent of dilatation should not be more than necessary for adequate mobility of the cannula to be used. Generally, it is approximately 1.0 mm. more than the number of weeks of gestation.

The tip of each successive dialator should go no further than just beyond the internal os of the cervix.

Entry of the dilator into the uterine cavity beyond this point increases the risk of perforation.

When there is much resistance. Do not forcefully push the dilator, leave it in place for half to one minute, sometimes applying xylocaine gel to the dilator helps.

6. **Introduce the suction cannula** with an external diameter equal to the number of weeks of gestation, into the uterine cavity (fig. 10), until it touches the fundus, then withdraw the cannula slightly.

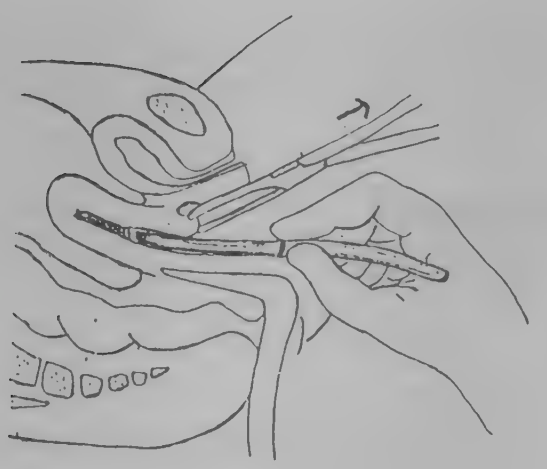


Fig. 8 Dilator held with a pen grip introduced into cervix

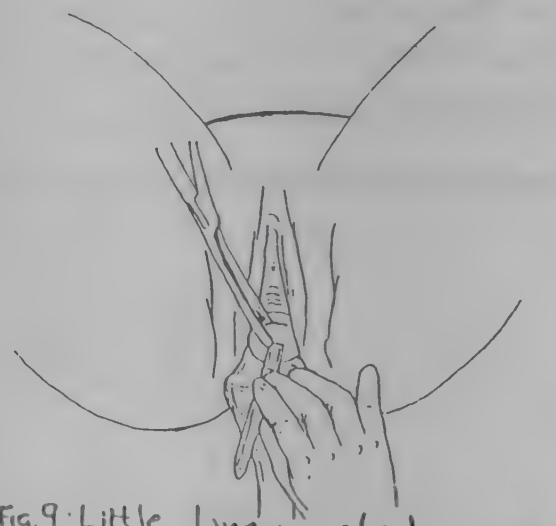


Fig. 9 Little finger abuts on p as gaurd while inserting

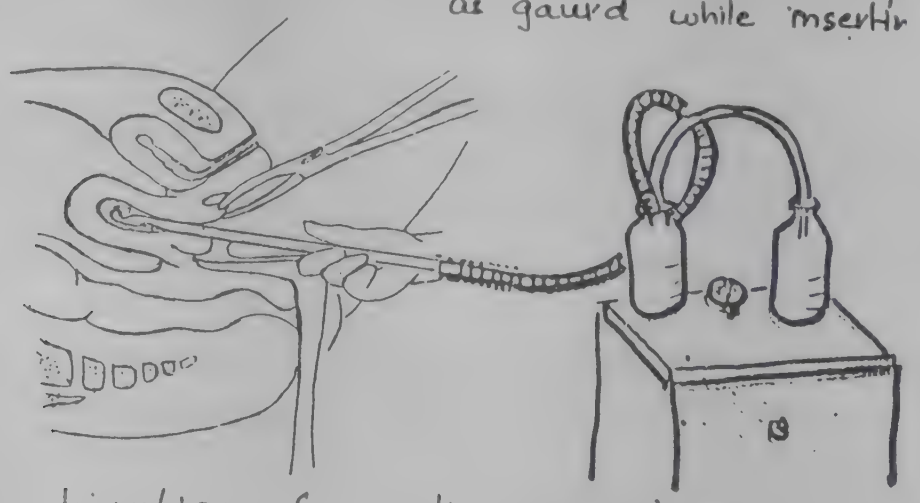


Fig. 10 Insertion of suction cannula

7. **Connect the cannula to the plastic tubing** connected to the suction machine.

Utmost care is required to maintain asepsis at this stage. The portion of plastic tubing held by hand for connecting to the suction cannula should be property covered with a sterile towel or another piece of sterile tubing (about 20cm. long) can be kept which is connected between the cannula and plastic tubing.

8 **Activate the suction,** raising the negative pressure to 70cm. of mercury. In case of metal cannula, suction is activated by pressing against the hole on the thumb grip.

9. **Evacuate the uterine contents** by rotating the cannula from side to side as well as to and fro, with slow controlled motion, till the cavity is completely evacuated.

The cannula is withdrawn after switching off the suction. *Introduction or withdrawal of the cannula with the suction activated can result in damage to the cervical epithelium.*

10. **End point of the procedure is indicated** when
    * uterine contents are no more seen coming through the cannula/coming into the suction bottle,
    * tightening grip of the uterus is felt on the cannula,
    * feeling of greating sensation during to and from motion of the cannula.

Administer Inj. methyl ergometrine 0.2mg. im or iv at this stage.

11. **Confirm the completion of the procedure** by gently cureting the uterine walls with a curette (fig. 12).

Vigorous curetting should never be done as it may lead to synaechia formation and secondary ammenorhoea. In case woman desires CUT for contraception, it should be inserted at this stage.

12. **Remove the volsellum and check for bleeding** from volsellum bite. Withdraw the vaginal speculum. Clean the vaginal with antiseptic lotion.

13. **Inspect the aspirated material,** strain the aspirate in the suction jar and examine the products to check whether volume and contents are consistent with the period of gestation. Chorionic villi can be seen by floating the products in water (fig. 13). In case of doubt, products should be sent for histopathological examination.

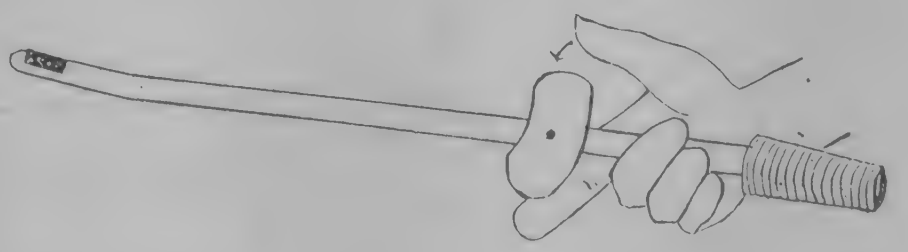


Fig. 11 Activation of suction in metal cannula by pressing on the hole on thumb grip

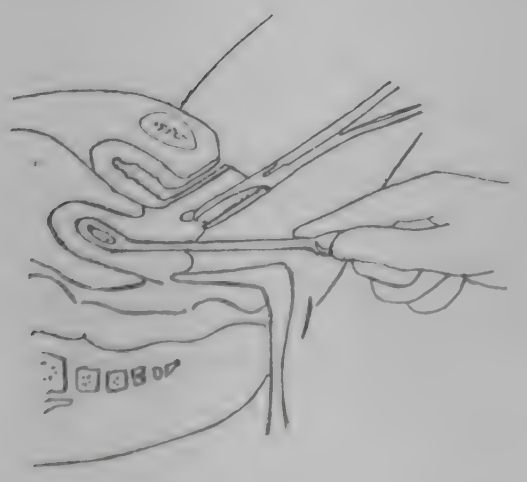


Fig. 12. : Curetting Uterine cavity

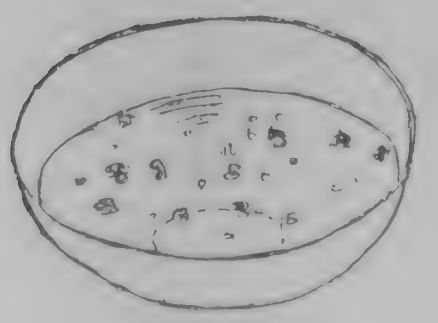


Fig. 13 Gross examination of aspirate

6.2 MENSTRUAL REGULATION

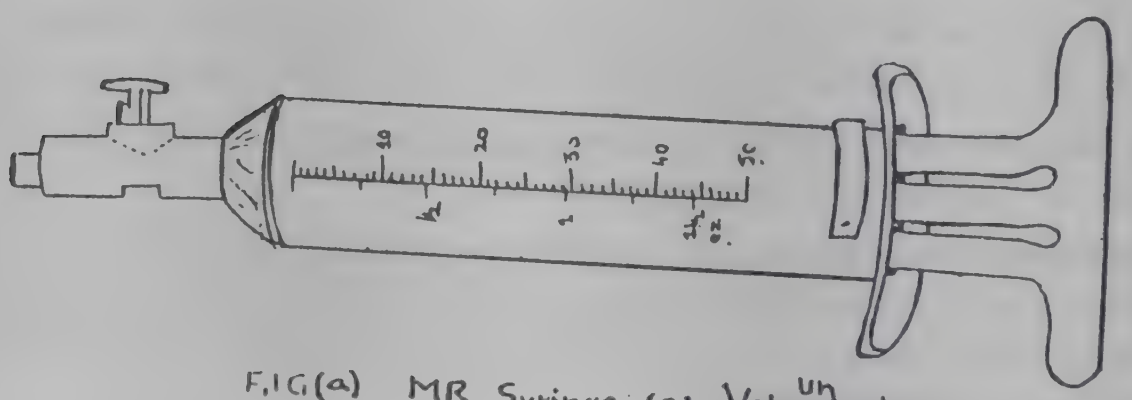
It is a procedure for removal of uterine contents, with in two weeks after a missed period, without confirming whether the women is pregnant or not. It is, in fact, a miniature suction curettage performed with a small flexible plastic cannula and hand held gynaecologic syringe. It aspirates the superficial endometrium along with the products of early conception, if present.

The procedure can be performed quickly in the out patient, without dilatation and without anaesthesia. The blood loss associated with the procedure is negligible and complication rate is low.

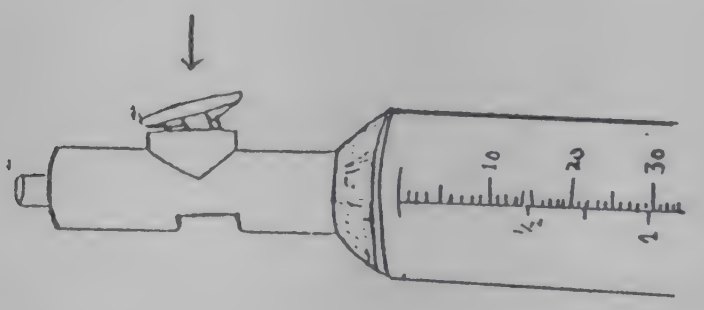
TECHNIQUE

A. Preparation of vacuum syringe and cannulae

1. Inspect the syringe and cannulae for any visible cracks or defects. A syringe must be able to hold vacuum in order to be effective. Discard damaged cannulae and syringes.
2. Check the plunger and the valve.
3. Close the pinch valve by pushing the button downwards and forwards with the thumb.
4. Grasp the barrel and withdraw the plunger handle fully until the catcher arms snap out and the plunger is locked firmly in its fully extended position (fig. 14).



FIG(a) MR Syringe (a) Valve UN Locked



(b) Pushing the button downward & forwards to lock the valve

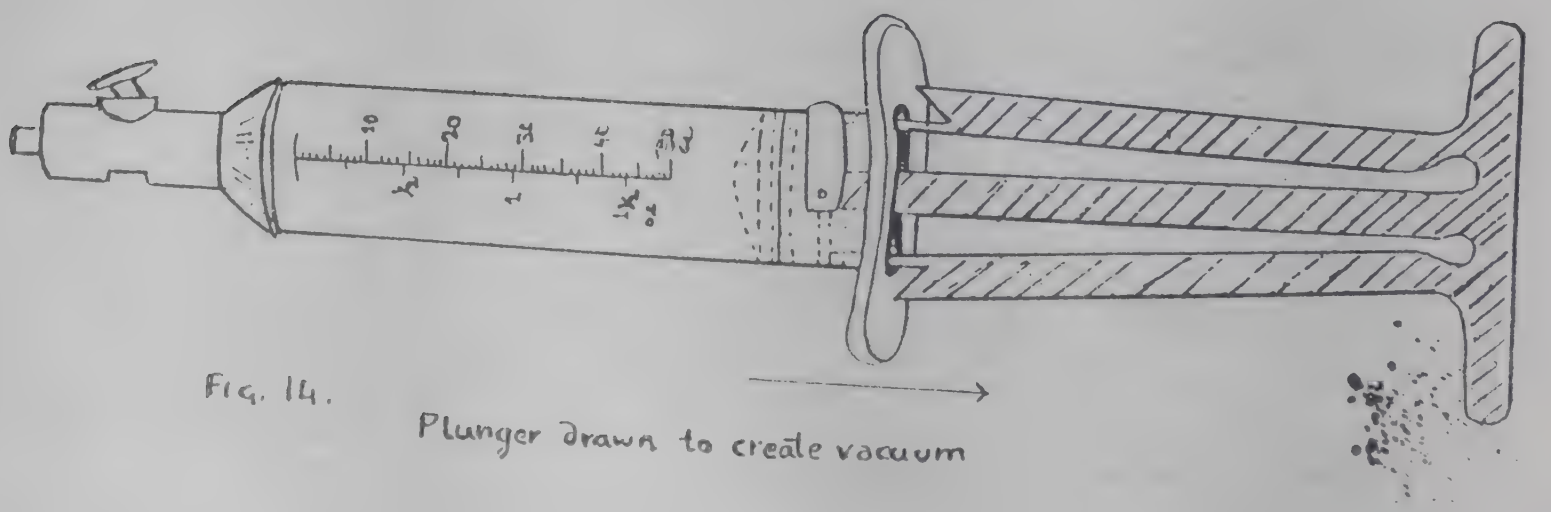


FIG. 14.

Plunger drawn to create vacuum

B. Steps of evacuation

1]

2]- Same as described for suction evacuation

3]

4. Insert the cannula gently through the cervix just past the internal os. Rotating the cannula with gentle pressure often helps the insertion. Push the cannula slowly into the uterine cavity until it touches funds, then withdraw the cannula slightly (fig. 10).
5. Attach the prepared syringe to the cannula, holding the end of the cannula in one hand and the syringe in the other. make sure that annula does not move forward into the uterus as the syringe is attached. (Fig. 15). Never create vacuum with the syringe attached to the cannula in the uterus.
6. Release the pinch valve near the tip of the syringe to transmit the vacuum through the cannula to the uterine cavity. Bloody tissue and bubbles begin to flow through the cannula into the syringe. (Fig.16).
7. Evacuate the uterine contents by grasping the cannula alongwith the syringe and rotating it gently from side to side through. 180 degree as well as to and fro. The cannula apertures should not be withdrawn beyond the os as it will cause the vacuum to be lost.

While the syringe is attached to the cannula in place never grasp it by plunger arms as it may accidentally, slip back into the syringe pushing air or tissue back into the uterine cavity.

8. End point is indicated when tissue stops flowing through the cannula, there is gripping of the cannula by the uterus and grating sensation of the empty uterus felt during to and fro motion of the cannula
9. Withdraw the cannula, detach the syringe and remove all the instruments.
10. Inspect the aspirated material. Note its volume. Retrieve the material by immersing the tip of the cannula in a container of water and pulling back & depressing the plunger alternately two to three times. Float the aspirate in the water to see the villi (fig. 13).

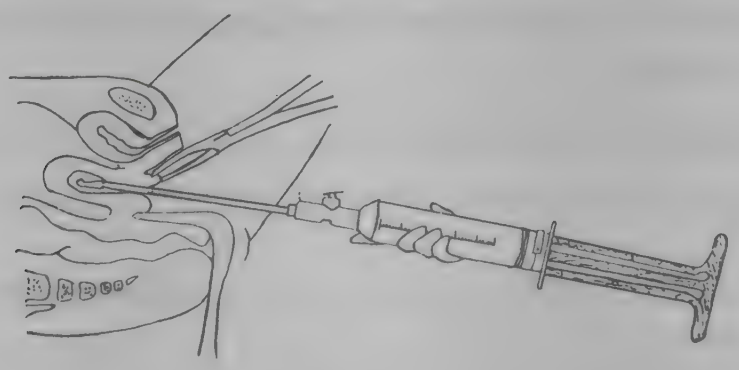


Fig. 15 Prepared syringe attached to Karman's cannula

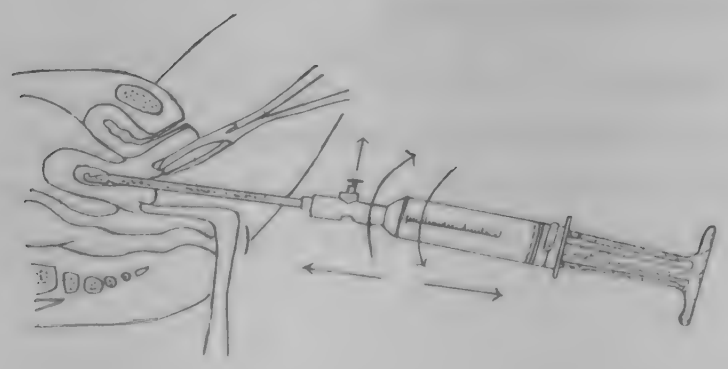


Fig 16 Release of valve followed by to and fro and rotatory motion of suction

6.3 TECHNICAL PROBLEMS DURING MENSTRUAL REGULATION

* **Syringe not creating or holding vacuum**

  If the syringe does ot hold a vacuum, check for any foreign particles or cracks in the o-ring or barrel and retest. If it still does not work, discard it.

* **Vacuum is decreased or lost during the procedure**

  A decrease in vacuum may sometimes occur before the aspiration is complete, either because the syringe is full or because the cannula is withdrawn beyond the os.

If the syringe is full

- Close the valve,
- Disconnect the syringe from the cannula, leaving the tip of the cannula in place inside the uterus,
- Empty the syringe into a container for inspection by opening the pinch valve and pushing the plunger into the barrel.,
- Reestablish a vacuum in the syringe, reconnect it to the cannula, and resume the aspiration.

It is optional to keep a second prepared syringe ready during the aspiration and switch syringes if one is full.

If cannula aperture is withdrawn beyond os

- Remove the cannula, taking care not to contaminate it through contact with the vaginal walls or other nonsterile surface,
- Close the pinch valve of the syringe,
- Detach the syringe from the cannula, empty the syringe, then reestablish a vacuum in the syringe,
- Reinsert the cannula if it has not been contaminated. If contamination has occurred, insert another sterile cannula,
- Reconnect the syringe, release the valve and continue aspiration.

* **Cannula is clogged**

  A lack of tissue or bubbles flowing into the syringe indicates that the cannula may be clogged. After removing the syringe and cannula, remove the material from the opening in the cannula using a sterile foreceps or sponge, taking care not to contaminate cannula. If contamination occurs, use another sterile cannula. Never try to unclog the cannula by pushing the plunger back into the barrel.

6.4 DILATATION AND EVACUATION (D&E)

In this method, the evacuation of uterine contents is done by ovum forceps or a blunt curettage alone, after rapid instrumental dilatation of cervix. The procedure is still commonly performed in rural areas, because of non-availability of electricity and suction apparatus. But it is no longer recommended as a procedure of choice as it is time consuming process and associated with more blood loss.

7. POST OPERATIVE CARE AND FOLLOW UP

After the surgical procedure for pregnancy termination is over, check the vital signs while patient is still on operation table. Make her rest comfortably at a place where she can be observed.

7.1 MONITOR PATIENT'S RECOVERY

* Check bleeding PV at least once before discharge. Check vital signs again.
* Check to see that abdominal cramping has deceased. It should normally subside within half to one hour. Prolonged cramping is not a normal phenomena.
* Discharge the patient when she is stable, can walk without assistance, usually after 2 hours.

7.2 INSTRUCTIONS ON DISCHARGE.

The woman is given information about:

A. Normal recovery & resumption of activity.

* She may feel some uterine cramping over the next few days which can be relieved by mild analgesics as Tab. Paracetamol
* Normal diet can be resumed on the same day.
* Heavy work should be avoided for one week.
* Normal menstrual period should be expected within four to six weeks.
* No vaginal douching or tampons. No intercourse until a week after bleeding stops.

B. Contraceptive counselling

Contraceptive counselling must be given once again if the woman has not accepted any method alongwith this MTP.

C. Instructions for prescribed medication

* Antispasmodic/analgesic like paracetamol s.o.s.
* Iron and folic acid tablets for one month.

7.3 FOLLOW UP

A. Emergency attention.

The women is instructed to report immediately to the centre if she experiences any of the following:

* Bleeding more than normal menstruation.
* Severe abdominal pain, distension or vomiting
* Fever, chill or malaise.
* Foul smelling discharge.

B. Routine visit at the centre

The woman is called for a routine visit at the centre after two weeks. At this time the medical officer should do an internal examination to rule out continuation of pregnancy, incomplete abortion & pelvic infection and to check the CuT, if it had been inserted along with MTP.

C. Home visit by HA(F) or MPW(F)

It is scheduled within one week to ensure the patient's well being and look for any signs and symptoms requiring emergency treatment.

8. NON SURGICAL METHODS

The rapid and forceful mechanical dilatation of cervix for first trimester MTP may sometimes be associated with complications as haemorrhage, inadequate dilatation leading to difficult evacuation, cervical incompetence resulting from damage to structural integrity of cervix, especially so in nulliparous women or in late first trimester abortions (10-12 weeks), where greater dilatation is required for introduction of a larger diameter cannula.

To over come this problem, agents may be used for slow dilatation of cervix prior to evacuation or now medical methods for termination of pregnancy are under trial that may be available as additional methods in future.

8.1 SLOW CERVICAL DILATATION PRIOR TO EVACUATION

A- Hygroscopic Agents

Hygroscopic agents act by radial force, extracting water from the stroma and swell without lengthening, resulting in gradual, atraumatic and reversible dilatatio of cervix.

* Laminaria tents

Laminaria tents have been used since forties for causing very slow dilatation of cervix. Studies carried out by ICMR and WHO indicate that they are safe, effective and no associated with any increased risk of sepsis. But, it is expensive and not readily available.

* Isoptents

CDRI, Lucknow has brought a slow cervical dilator, made from Isapgol seed husk. Results of clinical trials have indicated that they are as effective as laminaria tents in causing slow cervical dilatation. Isoptents are available presterilised, can be inserted easily and take minimum six hours to achieve sufficient dilatation.

* Synthetic Hydrogels

Lamicel (Polyvinyl alcohol sponge with magnesium sulfage) Hypan (Hydrogel polymer dilator), Dilapen etc. are now available. These have been proven efficient for slow dilatation of cervix. significant reducing the need for additional mechanical dilatation.

Care should be exercised while inserting hygroscopic tents as complications like trapping, herniation. repture of membrances, perforation, migration and expulsion are known with all tents.

B. Prostaglandin Analogs

Prostaglandins increase the uterine activity and cause cervical dilatation. PGE analogs are availabl as vaginal pessary (eg. Gemeprost) or viscous gel (eg. cerviprime gel) that can be inserted easil three to four hours prior to evacuation. These drugs are costly, have to be kept under refrigeratio may be associated with side effects as diarrhoea, vomiting, fever, chills, flushing.

8.2 NON SURGICAL METHODS FOR MTP

A. Antiprogestins (RU 486)

Since progestrone is the prime support hormone for early pregnancy, antiprogestational agent can start abortion by removing the progesterone support, but success rate as assessed by complet abortion is relatively low with RU 486 alone.

B. Prostaglandin Analogs

Prostaglandins increase uterine activity and can be used by various routes for expulsion of product of conception. Again, the success rate as assessed by complete abortion is relatively low wit prostaglandins alone.

C. Combination of RU 486 and PG analogs

In most countries, RU 486 administration is followed by administration of prostaglandin analogues (E, E_1 or F_1 by various routes), - 48-72 hours later. Complete abortion is achieved in over 90-95% of cases. ICMR trials have indicated that use of 200 mg RU 486 along with 5 mg. PGE2 vaginal gel is as effective as RU 486, 600mg followed by PGE_2 gel. clinical trials are underway to compare the efficacy of 200mg RU 486 with 5 mg of 9 methylene PGE_2 vaginal gel or 600 microgram of oral PGE_1.

If these studies confirm safety and efficacy of the method, these may, provide to be an additional method available at CHC, district hospitals for providing safe abortion services, to women who prefer nonsurgical MTP.

9. COMPLICATIONS & MANAGEMENT

Possible complications can be :

* Immediate
    - Complications of local anaesthesia
    - Complications of MTP procedure
* Delayed
* Remote

9.1 IMMEDIATE COMPLICATIONS

A. COMPLICATIONS OF LOCAL ANAESTHESIA :

* SYSTEMIC TOXIC REACTION

Though very rate, it is the most serious complication of local anaesthesia. This occurs because of inadvertent intravenous administration of the drug and can be prevented by aspiration before injection to make sure that needle is not in the blood vessel.

Patient usually complaints of parasthesia, drowsiness, vertigo, blurred vision, twitching. There may be convulsion, vomiting or diarrhoea. Breathing may become rapid and shallow and cyanosis might occur.

Treatment

* Head low position,
* Oxygen administration,
* Suction to maintain patent airway,
* Rapid infusion of physiological solutions,
* Inj. Diazepam 10mg. iv. or Inj. Dilantin 100mg. in case of convulsions,
* Transfer the patient to a higher centre when the patient is stabilised for completion of the procedure under general anaesthesia.

TM-120 N94
5371

* **HYPERSENSITIVITY AND ALLERGIC REACTION**

Sensitivity is not related to dosage and can occur even with sensitivity test. It may occur immediately or several hours after the procedure and is manifested by urticaria, bronchospasm, joint pains, swelling of eyelids etc.

Treatment :

* Inj. Avil IM/IV or Inj. Phenargan 25 mom. im
* Inj. Efcorlio 100mgm. or Inj. Dexamethasone 4-8mgm. IM/IV
* Adrenaline 1:(1000) 1cc. s/c
* Oxygen administration

B. COMPLICATIONS DURING MTP PROCEDURE :

* Excessive bleeding

Excessive bleeding at the end of procedure may be due to

* Cervical injury,
* Incomplete emptying of uterus
* Uterine atony
* Perforation uterus

Laceration of the cervix caused by volsellum or difficult dilatation may be controlled by pressure with sponge or may require stitching with catout chromic 0/1 using round body needle.

In case of bleeding from the uterine cavity after removal of the cannula:

* Check curettage should be done to remove any products that might have been left behind,
* Intravenous ergometrine 0.25 to 0.5 mg.,
* Oxytocin infusion 10 units in 500ml of 5% dextrose at 40-60 drops per minute,
* Bimanual message of uterus for two minutes,
* Arrange for transfer of patient to a CHC/FRU, if bleeding still persists.

* **PERFORATION UTERUS**

It is a uncommon but serious complication and may have grave consequences. MTP, is a blind procedure and the pregnant uterus being soft is prone to perforation, which can occur while passing the dilator, curette or cannula.

The risk of perforation is higher in certain cases as :-

* Nullipara whose cervix is not sufficiently soft and difficulty in dilating the os may result in false passage.
* Acutely anteverted/retroverted uterus.,
* Repeated termination of pregnancy.
* Fibroid uterus or septum distorting the uterine cavity.
* Previous uterine surgery (caesarion section).
* Misdiagnosed pregnancy during lactational amenorrhoea.

To avoid perforation

* Property assess the size and position of the uterus,
* Straighten the cervical canal by traction on volsellum while inserting the instruments into the uterine cavity,

Introduce the dilators in a manner described in the technique.

Suspect perforation any of the following is seen:

* The instruments pass through the uterine cavity without any resistance.
* Length of instrument going inside is much greater than the assessed size of the uterus.
* Difficulty in withdrawing the cannula.
* Yellow fatty tissue seen on withdrawal of the cannula.
* Patient complains of severe abdominal pain.
* Signs of shock.

Management

* Stop the procedure as soon as perforation is suspected,
* Remove the instruments,
* Raise the foot end,
* Start intravenous infusion,
* Shift the patient to higher centre,
* Give Inj. methergine 0.2mg. iv. if the patient is bleeding. It should not be given if there is suspected herniated omentum or intestinal loop,
* Do not attempt to replace the omentum or intestinal loop if it has herniated through the perforation.

If the perforation goes undetected and suction is continued it may cause serious damage to intestines, bladder, uterine blood vessels etc. Therefore adequate precautions must be taken so as to prevent this complication and if it occurs, it should be recognised immediately for prompt and proper management.

* **BROKEN TIP OF PLASTIC CANNULA**

Occasionally the tip of the plastic cannula breaks off and remains in the uterus. If this happens, use a fresh cannula to complete the procedure.

Do not keep exploring the cavity. The detached tip can be left in place and will usually be expelled spontaneously.

* **SYNCOPE (FAINTING)**

This is usually due to para sympathetic reaction to pain stimuli or due to too early ambulation after MTP. It may also be due to undetected excessive bleeding or perforation.

Patient complaints of giddiness and sinking sensation. On examination there may be pallor, cold clammy skin, weak pulse and hypertension.

Preoperative counselling, gentle handling during surgery and post-operative rest will minimise this complication. The symptoms and signs are transient. Lowering the head end, reassurance and hot drinks help. If persistent, rule out excessive bleeding and manage as outlined earlier.

9.2 DELAYED COMPLICATIONS.

* **INCOMPLETE EVACUATION**

It is the commonest complication. Patient presents with excessive or prolonged bleeding per vaginum, fever or pain abdomen. On examination, uterine size would not have come back to normal. Internal os may be open or closed.

The condition is preventable by ensuring complete evacuation with check curettage and quantitative assessment of the aspirated material. Treatment is by re-evacuation under antibiotic cover at a higher centre.

* **CONTINUATION OF PREGNANCY.**

Sometimes there may be failure to terminate pregnancy, especially after menstrual regulation. Since the conceptus is very small, it may be lying near the cornua at the fundus and may fail to get sucked. Other causes may be:-

* Failure to assess the size and position of uterus.

* Presence of fibroids leading to suction of cervical canal only rather than the uterine cavity.

* Difficulty in dilatation may result in formation of false passage and continuation of pregnancy.

* Small size cannulae with small openings.

* Ineffective suction pump system can also result in procedure failure.

* INFECTION

Infection is a risk of all intra uterine operations. The symptoms generally appear on the second or third day after the procedure but can be delayed for upto ten days.

Infection should be prevented by taking utmost care while performing the procedure that all the instruments used are properly sterilised and no touch technique is observed. The parts of instruments that will enter the uterus should not touch objects or surfaces that are not sterile, including the vaginal wall, before being inserted.

The signs of infection are fever, abdominal pain, pelvic tenderness or subinvolution of uterus and bleeding per vaginum. In severe cases patient may present with signs of peritonitis or septic shocks.

Treatment is with antibiotics; and re-evacuation if there is evidence of retained products. It should preferably be done at a higher centre. Cases of peritonitis or septic shock should also be referred to a higher centre for proper management.

9.3 REMOTE COMPLICATIONS

* CERVICAL INJURY

Permanent structural damage to cervix may result from rapid mechanical dilatation beyond 10mm. which may be forcible. This may lead to cervical incompetence, mid-trimester pregnancy losses and preterm births.

* CHRONIC PELVIC PAIN

Chronic pelvic inflammation following MTP may result in secondary infertility, ectopic pregnancy and menstrual disorders.

* **ASHERMANN'S SYNDROME**

It may occur due to vigorous curettage leading to secondary amenorrhoea and infertility.

* **OBSTETRIC COMPLICATIONS**

Complications may occur during future pregnancies eg. adherent placenta and uterine repture due to previous undiagnosed perforation in MTP.

* **PSYCHOSOMATIC SYMPTOMS**

Long term depression may be seen sometimes, especially if the termination has been carried out for medical reasons or has been enforced by the woman's husband or family members. Thus abortion counselling has an important role to play through the pre- and post- abortion period.

10. INFECTION CONTROL

The essentials of infection control in MTP are same as those applied to any condition involving surgical intervention so as to minimise infection due to micro-organisms and to prevent transmission of hepatitis B, STD, AIDS.

10.1 UNIVERSAL PRECAUTIONS

The universal precautions should be understood and applied by all medical and paramedical staff involved in providing these services. There should be frequent monitoring of staff for adherence to protocols.

The basic elements include :

* **Handwashing** thoroughly with soap and running water,
  - Before carrying out the procedure,
  - Immediately if gloves are torn, hand is contaminated with blood or other body fluids,
  - Soon after the procedure, hands should be washed with gloves on and again after removing the gloves.
* **Barrier Precautions :** using protective gloves, mask, waterproof aprons, gowns.
* **Strict Asepsis** during operative procedure; cleaning of operative site, No touch technique i.e. any instrument or part of instrument to be inserted into the cervical canal must not touch any non-sterile object surface prior to insertion.
* **Decontamination & Cleaning** of all instruments immediately after each use.
* **Sterilisation/High level disinfection** of instruments with meticulous attention.
* **Appropriate Waste Disposal.**

10.2 STERILISATION & MAINTENANCE OF EQUIPMENT

The four basic steps for processing of instruments are :

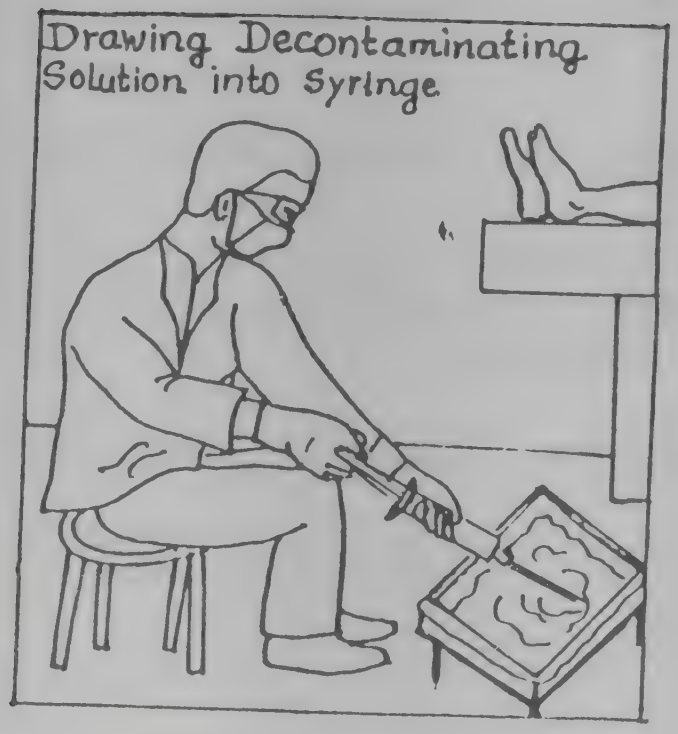
STEP 1 : DECONTAMINATION

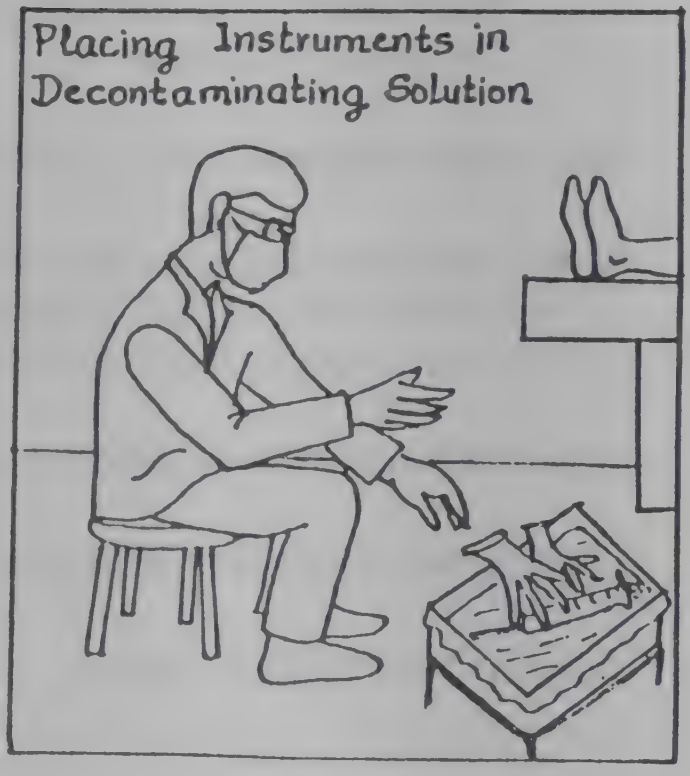
Immediately after use, soak all instruments, gloves, cannulae and syringes including menstrual regulation syringe for ten minutes, in 0.5% hypochlorite solution, which should be kept ready in a plastic bucket next to treatment table.

For syringes, the solution should be drawn through the cannula, into the syringe, which should then be soaked into the solution.

When removing items, use gloves to avoid contact with skin. A strainer or plastic bag with holes may be helpful in removing instruments from the bucket.

The solutions should be changed daily or more frequently if grossly contaminated. As chlorine solution can corrode the metal in metallic articles, exposure should be limited to ten minutes and items should be washed immediately after removing them.





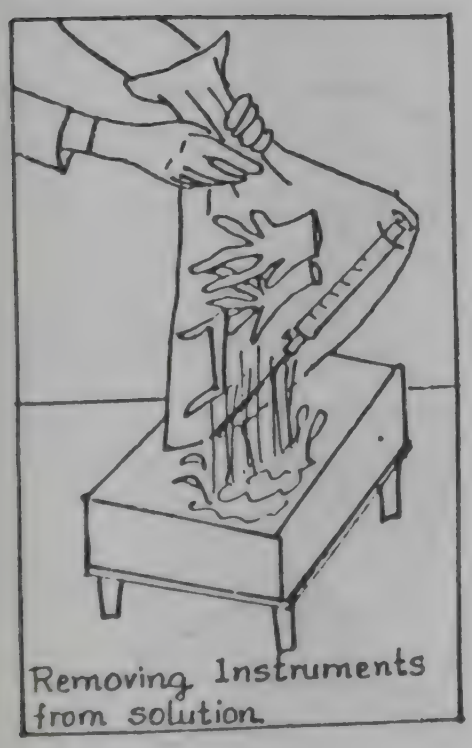
STEP 2 : CLEANING

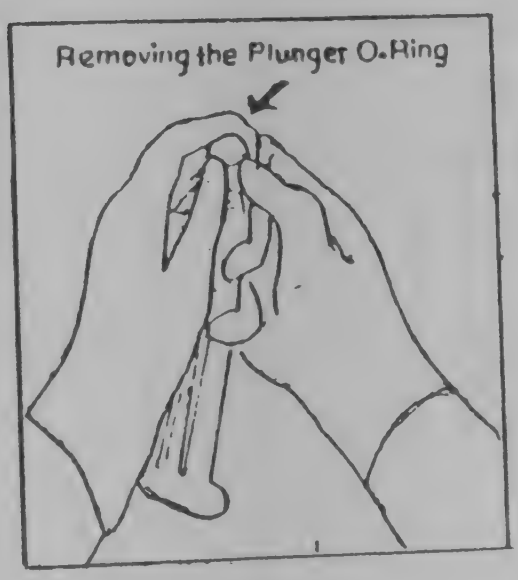
After decontamination, items should be washed thoroughly in lukewarm water with detergent to remove all organic material. Hot water should not be used because it can coagulate protein such as blood, making it hard to remove. Detergent must be used as water alone with not remove proteins or oils. Soap is not recommended as it can leave a residue which is difficult to remove.

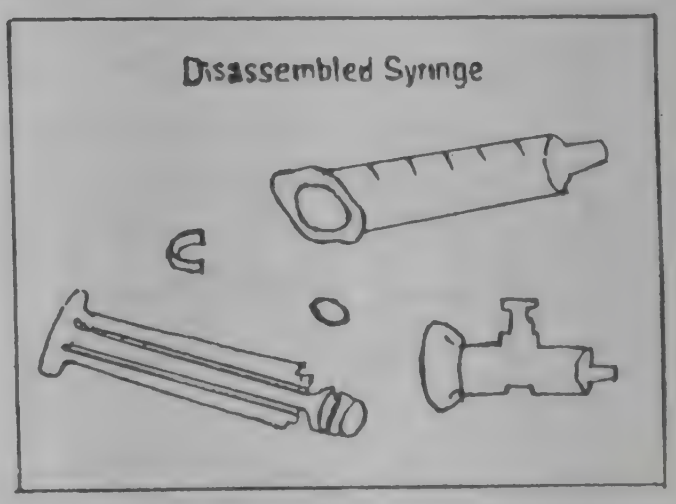
To clean the tip of cannulae, flush it out with syringe using water and detergent solution or flick the top of cannula with a finger tip. Do not use brushes or other small objects to remove matter as they can scratch the inside of cannulae, creating creviceswhere organic material can get trapped.

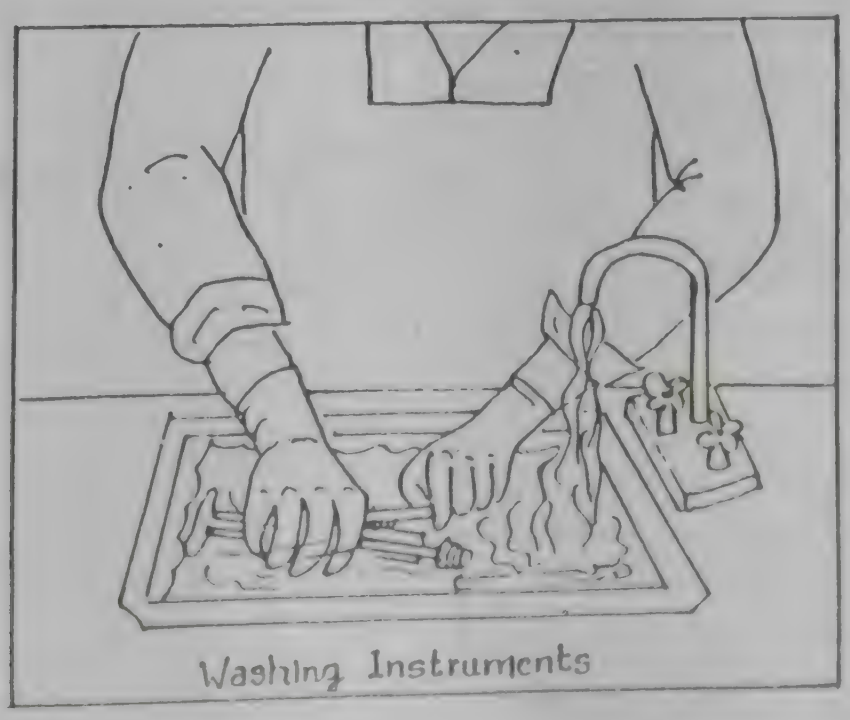
Syringe is disassembled and washed thoroughly, scrubbing with a soft brush (tooth brush), holding under water to prevent spraying of organic material.

After washing, items are rinsed thoroughly with clean water and dried by air or with a clean towel. Wet instruments should not be placed into chemical disinfectants because water may dilute the chemicals. Drying is not necessary for cannulae that are to be boiled.


Removing Instruments from solution






Washing Instruments

STEP 3 : STERILISATION/HIGH LEVEL DISINFECTION

A. Metallic Instruments

* Autoclave or Steam sterilisation (using pressure cooker) at 121oC under a pressure of one atmosphere for 30 minutes if packed in large packages or drum and for 20 min. if run in open trays.

* Boiling for at least 20 minutes in clean water to achieve HLD. Care should be taken to see that instruments are fully immersed in water: the pot is covered with lid; timing starts after the water starts boiling; no new items are added after the timing starts. An dry before use or storage.

B. Plastic Cannulae & MR Syringe

* Chemical disinfection or sterilisation

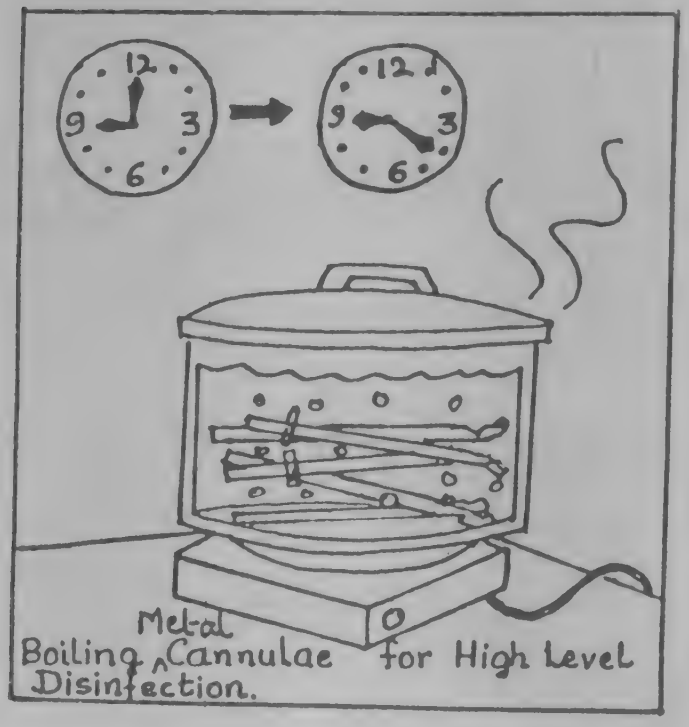
  Submerging the items in 2% activated gluteraldehyde for 20 minutes achieves HLD. For sterilisation they have to be soaked for 10 hours.

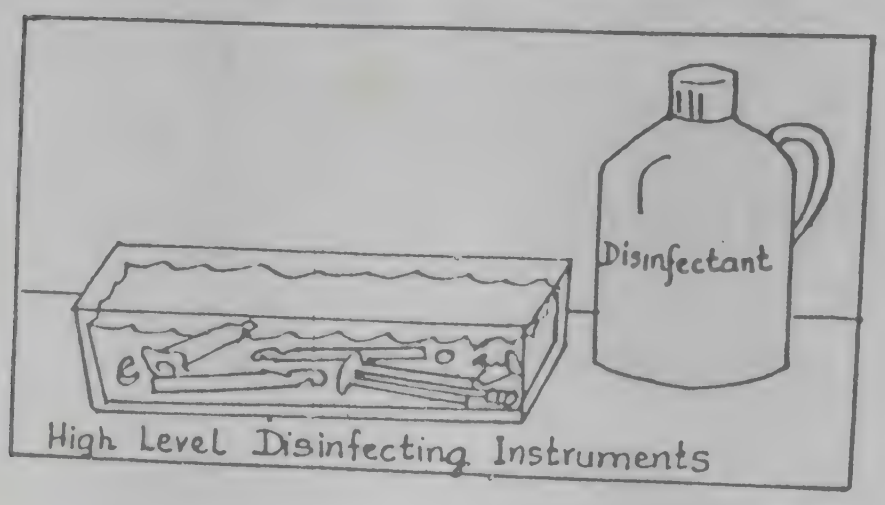
  Rinse with sterile water, Air dry before storing.

* Do not use iodine or formalin.

* Do not boil or autoclave.

* Do not boil or autoclave





C. Rubber goods (Reusable gloves, tubing, catheters)

* Autoclave at 121oC under a pressure of one atmosphere for 20 minutes. Tubing should be rolled in big circles to prevent kinking.

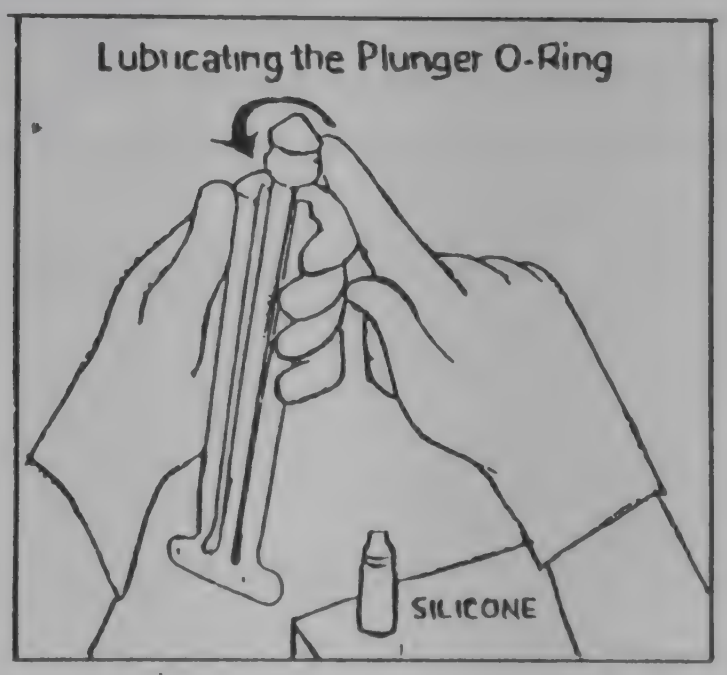
D. Glass syringes, Needles

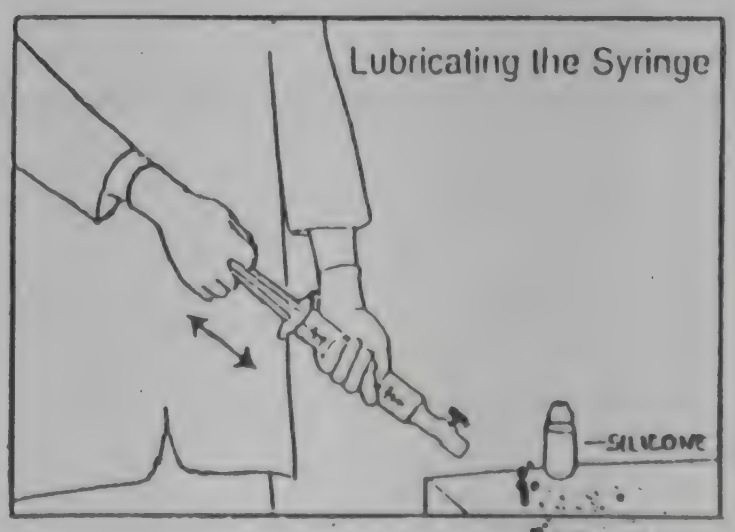
* Autoclave or boil as in A. Chemical disinfection should not be used for them.

STEP 4 : STORAGE/REASSEMBLY

* After sterilisation/HLD equipment should be handled with sterile/HLD sponge forceps or cheatle forceps.

* Items should be stored in sterile/HLD covered trays or wrapped in sterile paper or cloth without touching the instrument or inside of sterile wrap.





TM-120
31
05371
COMMUNITY HEALTH CELL
LIBRARY
AND
DOCUMENTATION
UNIT

* Cannulae or instruments should not be stored in disinfectant solution or in previously boiled water as they may become recontaminated.

* Sterile packages or trays should be dated and used within one week. If not used within a week, item should be recleaned and resterilised.

* Syringes are reassembled after air drying all the parts. O ring and plunger or MR syringe is properly lubricated before reassembling and is checked for vacuum tightness before storing.

10.3 WASTE DISPOSAL

After completing the MTP procedure, all potentially infectious waste should be decontaminated before disposal. While still wearing gloves, these items should be immersed in 0.5% bleach solution for 20 minutes. The responsibility for this should be taken by the medical and paramedical personnel conducting the procedure, so as to minimise the risk of accidental infection to less trained individuals involved in cleaning and sterilisation.

Once disinfection has been assured these wastes can be disposed off by incineration/burial. In small centres where incinerators may not be available, simple oil drums may be used as incinerators. Decontaminated plastic may be sold to appropriate industry for recycling.

11. CONCLUSION

At the end of the training, the trainee must acquire the following knowledge, attitudinal changes and practical skills so as to attain high level of competence in the conduction of MTP.

Knowledge

1. Role of abortion in maternal mortality and morbidity
2. Medical Termination of Pregnancy Act,
3. Essential Equipment and supplies,
4. Proper selection of cases,
5. Risks and complications.

Attitudinal changes

1. Understand the importance of supportive counselling and make the client comfortable,
2. Must have a positive attitude towards psycho-social aspects of woman and not refuse MTP even if it is felt to be requested upon for flimsy reasons,
3. Must counsel for appropriate contraception at the time of MTP. However, Not to refuse MTP even in concurrent contraception is not accepted.
4. Adequate supervision of all staff, good monitoring and recording system.

Practice

1. Acquire the skills required for vacuum aspiration,
2. Ability to recognise complications and adhere to protocols of treatment & referrals at all levels.
3. Careful adoption of infection control measures,
4. Ensure proper maintenance of all equipment,
5. Educate the public about the availability of safe abortion in legal settings, performance of early abortions.

MEDICAL TERMINATION OF PREGNANCY ACT

Medical termination of pregnancy Act, 1971 came into force from 1.4.1972. Implementing rules and regulations were revised in 1975, to simplify the procedure for approval of the place and for ready availability of services.

Important sections and clauses from the Act are :

Conditions under which pregnancy can be terminated

Termination of pregnancy is permissible upto 20 weeks duration, if opinion is formed by one Registered Medical Practitioner (for pregnancies less than 12 weeks) or two registered medical practitioners (for 12-20 week preg.), in good faith, that :

1. Continuation of Pregnancy would involve a risk to the life of pregnant woman or grave injury to her physical or mental health.

2. There is a substantial risk of the Child born to suffer from such physical or mental abnormalities as to be seriously handicapped.

   Pregnancy resulting from rape and from failure of contraceptive methods constitutes a grave injury to mental health of the woman. Account may also be taken of the woman's actual or forseable environment in determining the risk to her health.

Place where MTP can be performed

Every pregnancy is required to be terminated at Government hospital or at a place approved by the Govt. for the purpose.

For approval of the place, an application has to be addressed to the District C.M.O. in form 'A' and the applicant has to make arrangements for inspection of the place.

Facilities needed for approval of a place :

* Safe and hygienic conditions,

* Operation table and instruments for performing abdominal or gynaecologic surgery,

* Anaesthesia equipment, Resuscitation equipment and sterilization equipment.

The C.M.D. after verifying the conditions, recommends it further to the respective state/U.T. Government. The certificate of approval should be conspicuously displayed at a place so as to be easily visible.

Experience or training required for MTP

As per the MTP Act, only a Registered Medical Practitioner having obstetrics and Gynaecology experience is authorised to perform abortion. Under the new MTP rules (1975) the District CMO is empowered to certify that a doctor has the necessary training in obstetrics and gynaecology to perform MTP. Previously it had to be done through the certification board.

A person having any one of the following experiences can be authorised:

a) For medical practitioner registered in a State Medical register immediately before commencement of the Act:

   * minimum experience of 3 years in the practice of obstetrics and gynaecology.

b) For practitioners registered on or after the date of commencement of the Act:

   * 6 months of housejob in obstetrics and gynaec. or,

   * one year experience in the practice of obstetrics and gynaecology at a hospital or,

   * If he/she had assisted, a Registered Medical practitioner in performance of 25 cases of MTP in an institution approved for training by the Govt.

   * Postgraduate degree or diploma holder in obs & Gynae.

Consent for MTP

Informed written consent of the woman is taken in form "c". Written consent of the guardian is required in case of a minor (under 18 years of age) or a lunatic.

Confidentially/Custody of forms

Abortion has to be treated as a statutory personal matter. As such abortion services are to be provided in strict confidence and the name of the abortion seeker is kept confidential.

FORM A

(See Sub-rule (2) of rule 4)

Form of application for the approval of a place under clause (b) of Section 4.

1. Name of the place (in capital letters)

2. Address in full.

3. Non-Governmental/Private/Nursing Home/Other Institutions*.

4. State, if the following facilities are available at the place.

   (i) An operation table and instruments for performing abdominal or gynaecological surgery.

   (ii) Drugs and parenteral fluid in sufficient supply for emergency cases.

   (iii) Anaesthetic equipment, resuscitation equipment and sterilisation equipment.

Place :

Date :

Signature of the owner of the place

*Strike out whichever is not applicable.

FORM B

(See Sub-rule (6) of rule 4)

Certificate of approval.

The place described below is hereby approved for the purpose of the Medical Termination of Pregnancy Act, 1971 (34 of 1971).

Name of the Place

Address and other descriptions

Name of the owner

Place :

Date : to the Government of the _____

FORM C

(See Rule 8)

I ..... daughter/wife of .....
aged about ..... years of .....
(here state the permanent address)
at present residing at .....
do hereby my consent to the termination of my pregnancy at .....
(State the name of place where the pregnancy is to be terminated)

Place :

Date :

Signature

(To be filled by guardian where the woman is a lunatic or minor.

I ..... son/daughter/wife of .....
..... aged about ..... years of ..... at
present residing at .....
(permanent address)..... do hereby
give my consent to the termination of the pregnancy of my ward .....
..... who is a minor/
lunatic at .....
(place of termination of pregnancy)

Signature

Place :

Date :

FORM I

(See Regulation 3)

.....
(Name and qualifications of the Registered Medical practitioner in block letters)

.....
(Full address of the Registered Medical Practitioner)

1. .....
(Name and qualifications of the Registered Medical Practitioner in block letters)

.....
(Full address of the Registered Medical Practitioner)

hereby certify that *I/We am/are of opinion, formed in good faith, that it is necessary to terminate the pregnancy of .....
(Full name of pregnant woman in block letters)

resident of .....
(Full address of woman in block letters)

for the reasons given below**.

*I/We hereby give intimation that *I/We terminated the pregnancy of the woman referred to above who bears the serial No. ..... in the Admission Register of the Hospital/approved place.

Signature of
Registered Medical Practitioner

Signatures of the Registered
Medical Practitioners

Place :

Date :

* Strike out whichever is not applicable.

** of the reasons specified items (i) to (v) write the one which is appro.

(i) In order to save the life of the pregnant woman.

(ii) In order to prevent grave injury to the physical or menta health of the pregnant woman.

(iii) In view of the substantial risk that if the child was born I would suffer from such physical or mental abnormalities as to be seriously handicapped.

(iv) As the pregnancy is alleged by pregnant woman to have be caused by rape.

(v) As the pregnancy has occurred as a result of failure of an contraceptive device of methods used by married woman or her husband for the purpose of limiting the number of children.

Note :

Account may be taken of the pregnant woman's actual or reasonable foreseeable environment in determining whether the continuance of a pregnancy would involve a grave injury to her physical or mental health.

Place :

Date :

Signature of the Registered Medical Practitioner

Signature of the Registered Medical Practitioners

FORM II

[See Regulation 4(5)]

1. Name of the State.
2. Name of Hospital/approved place.
3. Duration of pregnancy (give total No. only)
   (a) Upto 12 weeks.
   (b) Between 12-20 weeks.
4. Religion of women.
   (a) Hindu
   (b) Muslim
   (c) Christian
   (d) Others
   (e) Total
5. Termination with acceptance of contraception.
   (a) Sterilisation
   (b) I.U.D.
6. Reasons for termination : (give total number under each sub-head).
   (a) Danger to life of the pregnant woman.
   (b) Grave injury to the physical health of the pregnant woman.
   (c) Grave injury to the mental health of the pregnant woman.
   (d) Pregnancy caused by rape.
   (e) Substantial risk that if the child was born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.
   (f) Failure of any contraceptive device or method.

Signature of the Officer

Incharge with date

FORM III

(See Regulation 5)

ADMISSION REGISTER

(To be destroyed on the expiry of five years from the dated of the last entry in the Register)

S. No.	Date of Admission	Name of Patient	Wife/Daughter	Age	Religion	Address	Duration of Pregnancy
1	2	3	4	5	6	7	8

Reasons on which Pregnancy is terminated	Date of Termination of Pregnancy	Date of Discharge of Patient	Result and Remarks	Name of Registered Medical Practitioner(s) by whom the opinion is formed	Name of Registered Medical Practitioner by whom Pregnancy is terminated.
9	10	11	12	13	14

NIKHIL OFFSET,